



Mandatory STD Reporting

Medical providers and the Los Angeles County Department of Public Health working together to prevent and control STDs

► FIVE REPORTABLE STDs: *(California Code of Regulations, Title 17, Section 2500)*

Reportable within 7 calendar days

- ✓ Chlamydia
- ✓ Gonorrhea
- ✓ Chancroid
- ✓ Pelvic Inflammatory Disease

Reportable within 1 working day

- ✓ Syphilis

PROVIDERS REPORTING STD MORBIDITY WILL NOT BE IN VIOLATION OF THE HIPAA PRIVACY RULE.

Reporting of STD cases does not require patient consent and does not contradict the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The privacy rule allows covered entities to disclose protected health information to public health authorities when required by federal, tribal, state, or local laws [45 CFR 164.512(a)].

► HOW TO REPORT:

- ✓ **Obtain and complete a Confidential Morbidity Report (CMR) form**
 - Visit <http://publichealth.lacounty.gov/std/cmr.htm> or call (213) 741-8000 to obtain a form.
 - Complete on-line and print or complete by hand.
- ✓ **Include the following information:**
 - **Provider Information:** Name of diagnosing medical practitioner, facility/clinic name, address, telephone number.
 - **Patient Information:** Name, address, telephone numbers, occupation, age, date of birth, gender, marital status, race/ethnic group, gender of sex partners, and pregnancy status, and (for HIV patients only) if received HIV partner services.
 - **Diagnosis, Treatment, & Partner Information:** Diagnosis with symptoms and sites, date of specimen collection dates of onset (P & S only), treatment information, and number of partners elicited and/or treated.
 - **Congenital Syphilis:** Maternal information must be filled out in the congenital syphilis section of the infant's CMR. A separate CMR should also be submitted for the mother that contains infant information on congenital syphilis in section A and B.

► WHERE TO REPORT:

FAX both sides of CMR to: 213-749-9602
OR
MAIL to Department of Public Health, STD Program
2615 S. Grand Avenue, Room 450 Los Angeles, CA 90007

FOR HIV REPORTING:
CALL (213) 351-8516 OR VISIT
<http://publichealth.lacounty.gov/hiv/>

FOR INFORMATION AND QUESTIONS ABOUT STD REPORTING:
Visit <http://publichealth.lacounty.gov/std/providers.htm> or call (213) 744-3106

PATIENT'S LAST NAME

D O E

FIRST NAME

J A N E

M.I.

R

ADULT SYPHILIS

3
Cont.☐ Primary Syphilis

Onset Date (MMDDYY):

00-00-00

LESION SITES
(X all that apply):☐ Genital☐ Rectum☐ Oral☐ Other:☒ Secondary Syphilis

Onset Date (MMDDYY):

04-01-11

SYMPTOMS
(X all that apply):☐ Palmar/Plantar Rash☐ Other:☒ General Body Rash☐ Alopecia☐ Early Latent (≤ 1 year)☐ Late Latent (> 1 year)☐ Latent, Unknown Duration☐ Late Syphilis☐ NeurosyphilisDESCRIBE
SYMPTOMS

(The diagnosis of neurosyphilis must be accompanied by a staged diagnosis)

PREGNANT?

☐ Yes☒ No☐ Unknown

Specimen Collection Date (MMDDYY):

04-04-11

Partner information:

Number
elicited:

02

Number
treated:

01

Patient Treated:

☒ Yes☐ No

(If yes, give treatment/dose & dates below)

DATE(S) TREATED (MMDDYY)

04-04-11

Medication & Dose:

BENZATHINE PCN 2.4 MU IM X 1 DOSE

☒ RPR or☐ VDRL

Titer: 1: 256

☒ TP-PA or☐ FTA-ABS or☐ OtherReactive: ☒ Yes ☐ No☐ CSF-VDRL

Titer: 1:

CONGENITAL SYPHILIS (SEPARATE CMRs SHOULD BE SUBMITTED FOR MOTHER & INFANT)

INFANT INFORMATION

(Complete sections A & B if this is mother's CMR; Complete only B if this is infant's CMR)

INFANT'S LAST NAME

D O E

INFANT'S FIRST NAME

S T E V E N

INFANT'S BIRTH DATE (MMDDYY)

04-04-11

☒ Male☐ Female☒ Live Birth☐ Still Birth

WEIGHT (grams)

3020

SYMPTOMS (describe)

☒ No symptoms

GESTATION(wks)

39

Long Bone X-rays: ☐ Pos. ☐ Neg. ☐ Not Done

Serum RPR Lab Test Date (MMDDYY):

04-04-11

☒ Reactive

Titer: 1: 256

☐ Non-Reactive☐ Not DoneTiter 4x > mothers? ☐ Yes ☒ No

DATE INFANT TREATED (MMDDYY):

04-04-11

CSF Laboratory Test Date (MMDDYY):

04-04-11

VDRL: ☐ Non-Reactive☒ ReactiveWBC > 5/mm³:☒ Yes ☐ No

Protein > 50mg/dl:

☒ Yes ☐ No

MEDICATION / DOSE

PROCAINE PCN G 50,000 UNITS/
KG IM X 10 DAYS

MATERNAL INFORMATION

(Complete if this is infant's CMR)

MOTHER'S LAST NAME

MOTHER'S FIRST NAME

MOTHER'S BIRTH DATE (MMDDYY)

Lumbar Puncture Done: ☐ Yes ☐ No

MOTHER'S SEROLOGY AT DELIVERY

Lab Test Date (MMDDYY):

☐ RPR or☐ VDRL

Titer: 1:

☐ TP-PA or☐ FTA-ABS or☐ OtherReactive: ☐ Yes ☐ No

DATE(S) TREATED (MMDDYY)

MEDICATION / DOSE

MOTHER'S STAGE OF
SYPHILIS AT DIAGNOSIS☐ Primary☐ Secondary☐ Early Latent (≤ 1 year)☐ Late Latent (> 1 year)☐ Latent, Unknown Duration☐ Late Syphilis

OTHER REPORTABLE STDs

DIAGNOSIS

TREATED

DATE TREATED

MEDICATION / DOSE

☐ Pelvic
Inflammatory
Disease☐ Yes ☐ No☐ LGV☐ Yes ☐ No☐ Chancroid☐ Yes ☐ No

4

FAX BOTH SIDES TO:

(213) 749-9602

OR

MAIL TO:

STD PROGRAM

2615 S. GRAND AVENUE, RM. 450
LOS ANGELES, CA 90007

5

FOR STD CMR FORMS:

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